DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-37

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440 Subpart A

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 400,000
b. FFY _____ $ 2.6 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A page 10 and page 10a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A page 10 and page 10a

10. SUBJECT OF AMENDMENT: All medically necessary days to be paid at Missouri Rehabilitation Center and hospitals operated by the Missouri Department of Mental Health.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT cc
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dana Katherine Martin

14. TITLE:
Director

15. DATE SUBMITTED:
September 26, 2001

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
09/27/01

18. DATE APPROVED:
OCT 31 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
8/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Nanette Foster Reilly

22. TITLE:
Acting ARA for Medicaid & State Operations

23. REMARKS:

cc:
Martin
Vadner
Waits

SPA CONTROL
Date Submitted: 09/26/01
Date Received: 09/27/01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Missouri

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Description of Limitations

All services described below, except family planning procedures must be medically necessary in order to be reimbursable through the Missouri Medicaid Program. The specific program limitations may be found in much greater detail in the provider manuals as sponsored by the Missouri Department of Social Services.

For medically necessary services which are included as covered under provisions of this state plan or by reference, except for inpatient hospital services for which exceptions are herein provided separately, the state will consider extensions of limits to the amount, duration and scope, or the additions of specific services on an individual case-by-case basis. The requisites of recipient eligibility, provider program participation and state coverage of the type of medical service represented must be met. According to the circumstances of the individual case, the state agency, through a formal process of consideration, may approve such exception services on a retrospective or prior authorized basis. Applied uniformly as applicable, basic criteria of consideration will include, but not be limited to, relative probable effects on the health and medical condition of the recipient resulting from approval or denial of the exception, cost and cost effectiveness of exception approval considered from perspective of possible alternative services and related costs and health benefits.

Reimbursement for such exception services may be made on a retrospective or a prior authorized basis. Program reimbursement for services excepted through this process shall be in accordance with established fee schedules or rates for same or comparable services or such fee or rate for the total service or components determined by the state as reasonable with relation to charges.

1. Inpatient Hospital Services

The number of days which Medicaid will cover shall be limited to the lower of (A) or (B) or (C) -

(A) The number of days indicated as appropriate in accordance with whichever of the following length-of-stay schedules is applicable to the individual case:

(1) For the diagnosis at the 75th percentile average length-of-stay in the 1988 edition of the Length of Stay by Diagnosis and Operation, North Central Region;

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(2) An average length-of-stay schedule, as developed by the Medicaid agency, for limited categories of rehabilitation services provided in specific facilities;

(3) An average length-of-stay schedule, as developed by the Medicaid agency, for liveborn infants according to type of birth;

(4) For infants who are less than one (1) year of age at admission, all medically necessary days will be paid at any hospital. For children who are less than six (6) years of age at admission and who receive services from a disproportionate share hospital, all medically necessary days will be paid;

(5) Continued stay reviews will be performed for alcohol and drug abuse detoxification services to determine the days that are medically necessary and appropriate for inpatient hospital care;

(6) For children less than 21 years of age all medically necessary inpatient hospital services will be paid for at hospitals operated by the Missouri Department of Mental Health when furnished under the direction of a physician; or

(7) All medically necessary inpatient hospital services will be paid for at the Missouri Rehabilitation Center when furnished under the direction of a physician.

(B) The number of days certified as medically necessary by the Hospital Utilization Review Committee; or

(C) The number of days billed as covered service by the provider.

In administering this limitation, counting of the days which may be allowable shall be from the beginning date of an admission which has been certified, or exempted from certification, and for a continuous period of hospitalization or if late, the beginning date of recipient Medicaid eligibility or the first day of Title XIX coverage following exhaustion of Title XVIII Part A benefits.

Certification of inpatient hospital admissions occurring on and after November 1, 1989 shall be conducted in accordance with the provisions of state rule 13 CSR 70-15.020. The medical review agent for the state applies criteria for medical necessity and appropriateness of the admission. Denial of certification of admissions subject to review will result in program non-coverage of inpatient services if provided, or recovery if review is retrospective to provision of service and admission certification is denied.